AGING & INDEPENDENCE SERVICES
COUNTY OF SAN DIEGO ▪ HEALTH AND HUMAN SERVICES AGENCY
LONG TERM CARE INTEGRATION PROJECT

Aging & Independence Services (AIS)
Long Term Care Integration Project (LTCIP)
Update for the Health Services Advisory Board (HSAB)
July 16, 2015

The goal of the Long Term Care Integration Project (LTCIP) is to improve the delivery of health care and long term services and supports for older adults and persons with disabilities.

The Long Term Care Integration Project's Quarterly Stakeholder meeting was held on Friday, June 12, 2015 at Aging and Independence Services (AIS). The LTCIP continues to strive to enhance meaningful involvement of consumers, providers, caregivers, advocates and other key stakeholders by providing three modes of participation in the quarterly meetings: in-person, telephonically and through web-streaming.

June's meeting focused on the County's Alzheimer's Project. Nearly 60,000 San Diegans age 55 years and older are living with Alzheimer's disease or other dementias, and this figure is expected to grow by 30% to nearly 100,000 by 2030. Alzheimer's disease is the third leading cause of death in San Diego County and costs our local economy's caregivers, taxpayers and healthcare system billions of dollars a year. In May 2014, County Board of Supervisors Dianne Jacob and Dave Roberts declared Alzheimer's disease as one of the region's leading public health priorities by launching "The Alzheimer's Project," an unprecedented initiative to develop a regional roadmap that comprehensively addresses this devastating disease. Aging & Independence Services Deputy Director, Mark Sellers, provided an overview of the project and explained how the project's recommendations will inform our community's response to this deadly disease. Meeting materials and webcast recording can be accessed on the LTCIP website at www.sdltcip.org.

The Community-based Care Transitions Program (CCTP)
The San Diego Care Transitions Partnership (SDCTP), a partnership between AIS and Palomar Health, Scripps Health, Sharp HealthCare and the UCSD Health System (13 hospitals) has completed the first half of its third year Program Agreement with the Centers for Medicare and Medicaid Services (CMS) to provide comprehensive, person-centered, health care and social services to high-risk, fee-for-service (FFS) Medicare patients across thirteen participating hospitals. Through the Community-based Care Transitions Program (CCTP), the SDCTP targets over 19,000 each year to receive specialized care transitions services that include support from transitional care nurses, licensed pharmacists, healthcare coaches and social workers. From January 1, 2015 through May 31, 2015, 6,943 high risk patients received care through the CCTP, and since the program began in January 2013, 33,171 patients have completed the program. The rate for patients who have been readmitted within 30 days to a hospital within the same health system has dropped to an all-time low of 8.8%.

Because of its outstanding success in improving the quality of care that patients receive as they transition across the care continuum, reducing avoidable readmissions and saving Medicare dollars, the SDCTP was selected to participate in a national research study, Project ACHIEVE. Led by Dr. Mark Williams at the University of Kentucky, Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence) is funded by the Patient Centered Outcomes Research Institute (PCORI). At the end of this three-year project, Project ACHIEVE will develop recommendations on best practices for patient-centered care transition interventions with guidance for scalability and large-scale dissemination. This will include insight into what interventions or combinations of interventions work best, for whom, and in what circumstances. Findings will be shared through national workshops and presentations, publications, and through the development of a Toolkit to provide guidance to hospitals, post-acute providers, and community organizations looking to improve care transitions.

The Coordinated Care Initiative (CCI)

As the Regional Aging and Disability Service and Advocacy Coalition for San Diego County funded by The SCAN Foundation, the LTCIP has actively supported the rollout of the Coordinated Care Initiative (CCI) in San Diego County by supporting both the CCI Advisory Committee and the CCI Communication Workgroup. At the July 1, 2015 CCI Advisory Committee meeting, updates on consumer experience were provided by key stakeholders. The CCI Advisory Committee has been focusing on CCI implementation and discussing how care coordination policies and procedures across the continuum of care providers can be augmented to increase administrative efficiencies that will enhance the Cal MediConnect consumer experience. The CCI Communication Workgroup met on June 24th to prepare for the upcoming IHSS teletown hall and to begin outlining the second phase of the communication and outreach plan, which includes the development of new materials and revamping the CCI virtual Resource Toolkit.

As of June 1, 2015, 18,260 San Diegans were actively enrolled in Cal MediConnect (CMC). Passive enrollment into CMC largely came to an end in March; however, there are 84 pending enrollments for dual eligibles who enrolled in a CMC Dual Special Needs Plan (D-SNP) after October 2014. The challenges impacting beneficiaries enrolled in CCI are becoming more complex and are taking more time to resolve. Beneficiaries are facing challenges related to continuity of care, medication reconciliation and Part D re-enrollment. On June 10, 2015, the Department of Health Care Services (DHCS) released a CMC opt-out data supplement that describes who is most frequently opting out of CMC by age, ethnicity and language. According to the DHCS dashboard, the overall opt-out and disenrollment rate in San Diego County remains at about 64%. Collectively, the data provided by DHCS will help the CCI Communication Workgroup identify who they need to reach, and to develop an outreach plan that will include the next generation of outreach materials.

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